Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca

Supplementary Health Expense -
Supplies & Equipment

Section 1 – To Be Completed By The Plan Member

Plan Policy Number: 6012

Last Name, First Name and Initial | EBFA Stakeholder Number:

Address: | City/Province/Postal Code: | Area Code and Telephone Number:

Birthdate (dd/mm/yy): Gender: ☐ Male ☐ Female Nature of Illness: Custom Made Item: ☐ Yes ☐ No

If This Claim Is On Behalf Of An Eligible Dependent, Please Complete The Following:

Dependent's – Last Name, First Name and Initial: | Date of Birth (dd/mm/yy):

Relationship (i.e. spouse, daughter, son):

Directions / Documents Required

Please attach all original paid receipts to this form if you wish to be reimbursed. The receipts must show the item has been paid in full. Cash register receipts and debit receipts will not be accepted as an original paid receipt.

When assigning eligible benefits to the supplier, please complete the assignment of benefits on the second page of the form, have the invoice completed (or attached to the form) and ensure the claim has been completed in full. Failure to answer all questions on this form will delay payment of your claim.

Physician recommendations must be completed by the patient's attending physician and not the practitioner.

The physician's recommendation must be completed for all major medical supplies.

The patient is responsible for securing this form and for any charges made for its completion.

Co-insurance Information

Do you or your dependents have any other coverage which may pay a benefit for any of the expenses being claimed on this form? □ Yes □ No If yes, please provide:

Plan Member – Last Name, First Name and Initial: | Date of Birth (dd/mm/yy):

Insurance Company: | Address Postal Code: | Telephone Number: | Policy Number:

Are you claiming any expense resulting from injuries or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law? □ Yes □ No

Does the person for whom you are submitting this claim have coverage through their Provinicial Plan? □ Yes □ No
Provincial Plan Number _____ in the Province of _____.

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Page 2 – Supplementary Health Expense

Supplies & Equipment

Assignment Of Benefits To The Supplier

I hereby authorize the Administrator of the Electrical Industry Insurance Benefit Trust Fund of Alberta to issue payment of all benefits relating to this claim directly to the supplier as stated in Section 2 below.

_____

Signature of Plan Member Date (dd/mm/yy)

Privacy Issues

I certify the charges for the medical supplies which are listed herein and for which the bills are attached were incurred by myself on account of myself or one of my eligible family members upon the recommendation and approval of the attending physician and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible family members.

I hereby authorize the release of information contained in, or pertaining to this claim to the Insurer, Board of Trustees, Medical Consultant, or any of their authorized representatives for purposes of settlement of this claim.

Signature of Plan Member Date (dd/mm/yy)

Section 2 - To Be Completed By The Attending Physician

Please **print** clearly: Patient's Name:_____

Attending Physician - Last Name, First Name and Initial:

Address: Postal Code: Area Code and Telephone Number:

Date treatment commenced (dd/mm/yy): Expected duration of treatment:

Recommended Medical Item(s) Describe in detail.

Diagnosis of medical condition:

Specific reason for recommendation of medical item(s) including symptoms, physical findings, description of the gait abnormality (if applicable).

Comments:

The appliance will be used for (check one): ☐ Daily Activity ☐ Sports Purposes ☐ Daily Activity and Sports Purposes

For replacement of a prosthesis, or other equipment, please provide: Date of Prior Placement _____(dd/mm/yy)
Reason for replacement:

Signature of Physician Date (dd/mm/yy)